FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0024745

Facility Name: WINNING WHEELS

Address: 701 E. THIRD STREET (Number) PROPHETSTOWN (City) 61277 (Zip Code)

County: WHITESIDE

Telephone Number: 815-537-5168 **Fax #** 815-537-5268

IDPA ID Number: 237136038001

Date of Initial License for Current Owners: 01/01/79

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 C(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact
Name: ALAN GAPINSKI **Telephone Number:** 815-778-3610

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/02 to 06/30/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) ALAN GAPINSKI

(Title) CEO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 80

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,200	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,200	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,744	2,584	507	6,835	8
9	SNF/PED					9
10	ICF	21,395			21,395	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,139	2,584	507	28,230	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.68%

D. How many bed-hold days during this year were paid by Public Aid?
785 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location
Date started 01/01/79

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 40 and days of care provided 507

Medicare Intermediary ADMINISTRATOR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year YES [X] NO [ ]

Tax Year: 6/30/2003 Fiscal Year: 6/30/2003

* All facilities other than governmental must report on the accrual basi

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	208,995	14,675	164	223,834	1,166	225,000		225,000			1
2	Food Purchase		195,006		195,006		195,006	(2,741)	192,265			2
3	Housekeeping	86,513	21,668		108,181	416	108,597		108,597			3
4	Laundry	60,361	11,100		71,461		71,461		71,461			4
5	Heat and Other Utilities			94,105	94,105		94,105	(5,500)	88,605			5
6	Maintenance	80,539	50,455	30,886	161,880	1,275	163,155	(500)	162,655			6
7	Other (specify):*											7
8	**TOTAL General Services**	436,408	292,904	125,155	854,467	2,857	857,324	(8,741)	848,583			8
	B. Health Care and Programs											
9	Medical Director			24,500	24,500		24,500		24,500			9
10	Nursing and Medical Records	1,126,836	200,194	7,558	1,334,588	(44,633)	1,289,955	(625)	1,289,330			10
10a	Therapy	252,381	6,426	1,720	260,527		260,527		260,527			10a
11	Activities	53,293	8,442	5,544	67,279		67,279		67,279			11
12	Social Services	82,696			82,696		82,696		82,696			12
13	Nurse Aide Training					53,855	53,855	(15,620)	38,235			13
14	Program Transportation	26,494	15,020		41,514	(23,654)	17,860		17,860			14
15	Other (specify):* COGNITIVE REHAI	46,925			46,925		46,925		46,925			15
16	**TOTAL Health Care and Programs**	1,588,625	230,082	39,322	1,858,029	(14,432)	1,843,597	(16,245)	1,827,352			16
	C. General Administration											
17	Administrative			196,600	196,600		196,600	(37,017)	159,583			17
18	Directors Fees											18
19	Professional Services			59,983	59,983		59,983	6,104	66,087			19
20	Dues, Fees, Subscriptions & Promotion			29,025	29,025		29,025	(4,935)	24,090			20
21	Clerical & General Office Expense	96,574	21,738	23,818	142,130		142,130	69,000	211,130			21
22	Employee Benefits & Payroll Taxe			382,675	382,675	(3,140)	379,535	30,562	410,097			22
23	Inservice Training & Educatior			8,245	8,245	(7,664)	581		581			23
24	Travel and Seminar			18,050	18,050		18,050	(3,884)	14,166			24
25	Other Admin. Staff Transportatior							773	773			25
26	Insurance-Prop.Liab.Malpractice			32,797	32,797		32,797	506	33,303			26
27	Other (specify):*											27
28	**TOTAL General Administration**	96,574	21,738	751,193	869,505	(10,804)	858,701	61,109	919,810			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,121,607	544,724	915,670	3,582,001	(22,379)	3,559,622	36,123	3,595,745			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WINNING WHEELS #0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			199,635	199,635	(13,505)	186,130	38,849	224,979			30
31	Amortization of Pre-Op. & Org											31
32	Interest			34,478	34,478		34,478	(3,380)	31,098			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			234,113	234,113	(13,505)	220,608	35,469	256,077			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					35,884	35,884		35,884			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,800	43,800		43,800		43,800			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			43,800	43,800	35,884	79,684		79,684			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,121,607	544,724	1,193,583	3,859,914		3,859,914	71,592	3,931,506			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals	(1,891)	2		4
5	Telephone, TV & Radio in Resident Room	(5,500)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient	(511)	21		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	34,674	30		9
10	Interest and Other Investment Incom	(4,086)	32		10
11	Discounts, Allowances, Rebates & Refund	(850)	2		11
12	Non-Working Officer's or Owner's Salar				12
13	Sales Tax				13
14	Non-Care Related Interes				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotiona				25
26	Income Taxes and Illinois Persona Property Replacement Tax				26
27	Nurse Aide Training for Non-Employee	(15,620)	13		27
28	Yellow Page Advertising	(90)	20		28
29	Other-Attach Schedule	(10,622)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (4,496)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organizatio Costs (Schedule VII)	76,088		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 76,088		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 71,592		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport	X		$ 35,884	38	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 35,884		47

STATE OF ILLINOIS

WINNING WHEELS

ID# 0024745

Report Period Beginning: 07/01/02

Ending: 06/30/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	ADVERTISING/MARKETING	$ (2,919)	20	1
2	FLOWERS	(425)	20	2
3	DONATIONS & CONTRIBUTIONS	(2,014)	20	3
4	OUT OF STATE TRAVEL	(4,139)	24	4
5	EMPLOYEES WORKING FOR OTHER FACILITY	(625)	10	5
6	RECOVERY OF FIRE DAMAGE FEES	(500)	6	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(10,622)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINNING WHEELS # 0024745 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,741)	0	0	0	0	0	0	0	0	0	0	(2,741)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(5,500)	0	0	0	0	0	0	0	0	0	0	(5,500)	5
6	Maintenance	(500)	0	0	0	0	0	0	0	0	0	0	(500)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,741)	0	0	0	0	0	0	0	0	0	0	(8,741)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(625)	0	0	0	0	0	0	0	0	0	0	(625)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	(15,620)	0	0	0	0	0	0	0	0	0	0	(15,620)	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(16,245)	0	0	0	0	0	0	0	0	0	0	(16,245)	16
	C. General Administration													
17	Administrative	0	0	(37,017)				0	0	0	0	0	(37,017)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	6,104	0	0	0	0	0	0	0	0	6,104	19
20	Fees, Subscriptions & Promotions	(5,448)	0	513	0	0	0	0	0	0	0	0	(4,935)	20
21	Clerical & General Office Expenses	(511)	0	3,439	66,072	0	0	0	0	0	0	0	69,000	21
22	Employee Benefits & Payroll Taxes	0	0	17,615	10,933	2,014	0	0	0	0	0	0	30,562	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(4,139)	0	255	0	0	0	0	0	0	0	0	(3,884)	24
25	Other Admin. Staff Transportation	0	0	773	0	0	0	0	0	0	0	0	773	25
26	Insurance-Prop.Liab.Malpractice	0	0	506	0	0	0	0	0	0	0	0	506	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(10,098)	0	(7,812)	77,005	2,014	0	0	0	0	0	0	61,109	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(35,084)	0	(7,812)	77,005	2,014	0	0	0	0	0	0	36,123	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINNING WHEELS # 0024745 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	34,674	0	4,175		0	0	0	0	0	0	0	38,849	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,086)	0	706	0	0	0	0	0	0	0	0	(3,380)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	30,588	0	4,881	0	0	0	0	0	0	0	0	35,469	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(4,496)	0	(2,931)	77,005	2,014	0	0	0	0	0	0	71,592	45

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
AMERICAN HEALTH ENTERPRISES	0.00%	BIG MEADOWS	SAVANNA	LYNDON PROGRESS		DAYTREATMENT
	0.00%	PLEASANT VIEW	MORRISON	CENTER	LYNDON	REHABILITATION
WINNING WHEELS	100.00%	STRIVE	PROPHETSTOWN	LYNDON PLAY &		
				LEARN CENTER	LYNDON	CHILD DAYCARE
				FRONTIER HOLLOW		INDEPENDENT
				APARTMENTS	PROPHETSTOWN	LIVING FACILITY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		DAYCARE BENEFITS	$	LYNDON PLAY & LEARN CENTER	100.00%	$ 2,014	$ 2,014	1
2	V								2
3	V		PROFESSIONAL SERVICES	196,600	AMERICAN HEALTH ENTERPRISES	0.00%	193,669	(2,931)	3
4	V				MANAGEMENT COMPANY				4
5	V								5
6	V		ADMINISTATIVE OVERHEAD		LYNDON PROGRESS CENTER	100.00%	77,005	77,005	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 196,600			$ 272,688	$ * 76,088	14

* Total must agree with the amount recorded on line 34 of Schedule VI

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	AMERICAN HEALTH ENTERPRISES, INC.								$		1
2	ALAN GAPINSKI	PRESIDENT	DIRECT MANAGEMENT								2
3	(100% OWNER - AHE, INC)										3
4								MANAGEMENT			4
5	WINNING WHEELS, INC.			0.00	73,370	18	36.00	FEES	41,275	17,3	5
6	S.T.R.I.V.E.					5	10.00	"			6
7	BIG MEADOWS, INC.					14	28.00	"			7
8	PLEASANTVIEW					10	20.00	"			8
9	OTHERS (NON-COST REPORTING)					3	6.00	"			9
10											10
11											11
12											12
13								TOTAL	$ 41,275		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offi
or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization AMERICAN HEALTH ENTERPRISES
Street Address 501 6TH AVE. WEST
City / State / Zip Code LYNDON IL. 61261
Phone Number (815-778-3683
Fax Number (815-778-4503

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	DIRECT COST	1	1	$ 63,635	$ 63,635	1	$ 63,635	1
2	17	ADMINISTRATIVE	GROSS REVENUE	11,468,000	5	278,001	278,001	3,958,000	95,948	2
3	22	BENEFITS	DIRECT COST	1	1	3,643		1	3,643	3
4	22	BENEFITS	%SALARY	527,291	5	46,165		159,583	13,972	4
5	19	DATA PROCESSING	GROSS REVENUE	11,468,000	5	17,687		3,958,000	6,104	5
6	19	ACCOUNTING	GROSS REVENUE	0		0		0		6
7	20	DUES,FEES,SUBSCRIPTIONS	GROSS REVENUE	11,468,000	5	1,485		3,958,000	513	7
8	21	SUPPLIES,PHONE	GROSS REVENUE	11,468,000	5	9,965		3,958,000	3,439	8
9	24	TRAINING, SEMINAR	GROSS REVENUE	11,468,000	5	739		3,958,000	255	9
10	25	ADMIN. TRANSPORTATION	GROSS REVENUE	11,468,000	5	2,240		3,958,000	773	10
11	26	INSURANCE	GROSS REVENUE	11,468,000	5	1,466		3,958,000	506	11
12	32	INTEREST WORKING CAP.	DIRECT COST	0		0		0		12
13	30	DEPR'N VEHICLES	GROSS REVENUE	11,468,000	5	8,487		3,958,000	2,929	13
14	30	DEPR'N EQUIPMENT	GROSS REVENUE	11,468,000	5	3,611		3,958,000	1,246	14
15	32	INTEREST VEHICLES	GROSS REVENUE	11,468,000	5	2,046		3,958,000	706	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 439,170	$ 341,636		$ 193,669	25

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offi
or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization LYNDON PROGRESS CENTER
Street Address 501 6TH AVE W.
City / State / Zip Code LYNDON,IL 61261
Phone Number (815-778-3610
Fax Number (815-778-4503

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	SALARIES-ADMINISTRATIVE	GROSS REVENUES	5,865,925	6	$ 99,732	$ 99,732	3,886,152	$ 66,072	1
2	22	BENEFITS	GROSS REVENUES	5,865,925	6	16,503		3,886,152	10,933	2
3										3
4										4
5	22	BENEFITS	% DAY CARE FEES	31,314	5	3,845		16,401	2,014	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 120,080	$ 99,732		$ 79,019	25

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	FARMERS NATIONAL BANK		X	MORTGAGE	$13,500.00	10/13/00	$ 750,000	$ 482,929	10/13/2006	6.1500	$ 34,478	1
2												2
3												3
4	AMCORE BANK - RELATED		X	VEHICLES	$624.50	1/2001	30,000	19,409	1/2006	9.0000	706	4
5	PARTY ALLOCATION											5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$14,124.50		$ 780,000	$ 502,338			$ 35,184	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 780,000	$ 502,338			$ 35,184	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ NONE Line #

* **Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

** **If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report

1. Real Estate Tax accrual used on 2002 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru	$	7

Real Estate Tax History

Real Estate Tax Bill for Calendar Year:

1998		8
1999		9
2000		10
2001		11
2002		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WINNING WHEELS COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0024745

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,500 B. General Construction Type: Exterior MASONARY Frame CONCRETE BLOCK Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization [ ] (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's groun (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable

F. Does this cost report reflect any organization or pre-operating costs which are being amortize [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 22,848 2. Number of Years Over Which it is Being Amortized 5 YEARS PER BOOKS (30 YE

3. Current Period Amortization: 762 PER REPORT 4. Dates Incurred: 1979

Nature of Costs: PRE-OPENING COSTS
(Attach a complete schedule detailing the total amount of organization and pre-operating costs

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	BUILDING SITE	504,424	1973	$ 23,500	1
2					2
3	TOTALS	504,424		$ 23,500	3

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	80		1979	1979	$ 1,526,858	$ 16,983	VARIOUS	$ 50,895	$ 33,912	$ 1,284,690	4
5			1979	1979	22,848		5	762	762	22,848	5
6			1979	1979	3,826		20			3,826	6
7			1985	1985	4,226	211	20	211		3,862	7
8			1987	1987	11,212	561	20	561		9,297	8
	Improvement Type**										
9	TILE FLOOR			1985	585	29	20	29		517	9
10	AIR CONDIONER-KITCHEN			1986	1,367		10			1,367	10
11	AIR CONDITIONER-COMPRESSOR			1986	2,576		10			2,576	11
12	CON			1986	2,093	105	20	105		1,735	12
13	LAVATORIES			1987	780	39	20	39		640	13
14	PATIO			1987	3,089	154	20	154		2,497	14
15	TRACK CURTAIN SYSTEM			1987	1,306	65	20	65		1,056	15
16	CEDAR / POST RAILS			1987	230		10			230	16
17	SHOWER DOORS			1987	350		15			350	17
18	BLACKTOP PATH			1987	5,946	297	20	297		4,633	18
19	BATH IMPROVEMENTS			1988	11,342	378	15	378		11,342	19
20	TV ANTENNA BOOSTER			1988	455		10			455	20
21	FAUCETS			1988	597	23	15	23		597	21
22	HEAT A/C UNIT			1988	2,869	112	15	112		2,869	22
23	MOTORS			1988	1,037		10			1,037	23
24	EMPLOYEE LOUNGE			1988	3,235	162	20	162		2,480	24
25	DOOR OPENERS			1988	3,505	156	15	156		3,505	25
26	BATH PARTITIONS			1988	764		10			764	26
27	BLACKTOP			1988	5,023	335	15	335		4,911	27
28	COUNTERTOP/SHELVES			1988	1,678	112	15	112		1,640	28
29	FITNESS TRAIL			1988	945		5			945	29
30	PARKING LOT SEALER			1988	4,000		4			4,000	30
31	BACK ROOM RENOVATIONS			1988	30,717	2,048	15	2,048		30,035	31
32	SIGNAGE			1988	872	44	20	44		639	32
33	HEATER MOTORS/THERMOSTAT			1988	1,010		5			1,010	33
34	LANDSCAPING			1989	4,715		10			4,715	34
35	BLACKTOP ROCK & SEALING			1989	5,906	394	15	394		5,447	35
36	DRAPES			1989	1,083		10			1,083	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	BATHROOM REMODELING	1990	$ 11,976	$	8	$	$	$ 11,976	37
38	WATER SOFTNER	1990	5,858		12			5,858	38
39	SIGN	1990	3,700	77	12	77		3,700	39
40	PARKING LOT LIGHTS	1990	6,258	417	15	417		5,490	40
41	SHRUBS	1990	1,235	82	15	82		1,077	41
42	CARPET	1990	2,669		5			2,669	42
43	BATHROOM IMPROVEMENTS	1991	12,802	853	15	853		10,455	43
44	WANDERGUARD	1991	2,772		7			2,772	44
45	AUTOMATIC DOOR OPENERS	1991	4,455		10			4,455	45
46	REMODEL DINING ROOM	1992	34,562	1,728	20	1,728		19,009	46
47	REMODEL A & B WINGS	1992	18,929	946	20	946		10,095	47
48	NEW HOT WATER BOILER	1992	4,272	285	15	285		3,014	48
49	RT CLINIC	1993	2,992	150	20	150		1,534	49
50	FLOWER BED	1993	1,142	57	10	57		1,095	50
51	LIGHTS & VENT KITCHEN	1993	3,777	189	20	189		1,904	51
52	ENGR & ARCHITECT LAUNDRY	1993	3,735	187	20	187		1,868	52
53	WATER HEATER & COND LAUNDRY	1993	4,813	321	15	321		3,208	53
54	BLINDS & VALENCES LOBBY & OFFICE	1993	3,295	165	10	165		3,103	54
55	LAUNDRY ROOM	1993	28,023	1,401	20	1,401		13,544	55
56	INTERIOR SIGN	1994	900	82	11	82		777	56
57	COUNTER TOPS RT CLINIC	1994	1,283	64	20	64		609	57
58	REDECORATE LOBBY	1994	29,817	1,491	20	1,491		13,915	58
59	GAS WATER HEATER	1994	2,149	143	15	143		1,313	59
60	REPLACE ROOF ON SHELTER	1994	514	34	15	34		311	60
61	REDECORATE OFFICE	1994	1,587	159	10	159		1,442	61
62	REDECORATE ROOMS & HALLS	1994	11,264	1,126	10	1,126		10,137	62
63	SHRUBS & PLANTS	1994	7,501	750	10	750		6,688	63
64	PATIO	1994	8,723	582	15	582		5,185	64
65	CARPETING	1994	680		5			680	65
66	COUNTER TOPS RT CLINIC	1994	1,241	62	20	62		548	66
67	DOOR ALARM SYSTEM	1994	6,962		7			6,962	67
68	DECORATION DINING	1995	1,870	187	10	187		1,590	68
69	ACCORDIAN DOORS	1995	12,071	604	20	604		5,080	69
70	TOTAL (lines 4 thru 69)		$ 1,910,872	$ 34,350		$ 69,024	$ 34,674	$ 1,579,661	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forwarc		$ 1,910,872	$ 34,350		$ 69,024	$ 34,674	$ 1,579,661	1
2	AIR CONDIONER	1995	3,575	358	10	358		2,890	2
3	NEW ROOF A & B WINGS	1995	42,900	2,145	20	2,145		17,160	3
4	GARAGE 24' X 58'	1995	27,086	1,354	20	1,354		10,383	4
5	SWING DOOR OPERATOR	1996	4,246	425	10	425		3,185	5
6	WIRING FOR NEW GARAGE	1996	3,384	226	15	226		1,692	6
7	CARPETTING	1996	811		5			811	7
8	GARAGE DOOR	1996	1,519	76	20	76		570	8
9	HEATER	1996	1,506	100	15	100		744	9
10	WALLPAPER	1996	471	47	10	47		349	10
11	CEILING TILE	1996	4,157	208	20	208		1,542	11
12	WALLPAPER BACK OFFICE	1996	587	59	10	59		436	12
13	FLOORING	1996	425	21	20	21		158	13
14	TILING FOR FLOORING	1996	4,105	205	20	205		1,505	14
15	GREY FLOOR GROUT	1996	237	12	20	12		86	15
16	STAIRS	1996	200	20	10	20		145	16
17	REMODEL KITCHEN	1996	13,551	678	20	678		4,912	17
18	CORNER PROTECTORS	1996	2,200	220	10	220		1,595	18
19	CARPET - DIETARY & MAIN	1996	415		5			415	19
20	COMPRESSOR FOR A/C	1996	6,500	650	10	650		4,279	20
21	CARPET - DIETARY & MAIN	1996	415		5			415	21
22	LAYING BRICK	1996	768	38	20	38		253	22
23	GARAGE DOOR	1996	667	33	20	33		220	23
24	BLACKTOP	1996	8,260	551	15	551		3,625	24
25	DISPOSAL	1996	950	63	15	63		417	25
26	CARPETING	1997	2,255		5			2,255	26
27	FAUCETS	1997	738	49	15	49		324	27
28	PAINTING	1997	1,948	195	10	195		1,282	28
29	LTILING FOR FLOORING	1997	18,869	943	20	943		6,211	29
30	LANDSCAPING	1997	1,480	148	10	148		975	30
31	SOFFIT	1997	4,495	225	20	225		1,274	31
32	SOFFIT ADDITION	1997	952	48	20	48		289	32
33	A/C COMPRESSOR AND CONTROLLER	1997	10,811	1,081	10	1,081		6,036	33
34	TOTAL (lines 1 thru 33)		$ 2,081,355	$ 44,528		$ 79,202	$ 34,674	$ 1,656,094	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,081,355	$ 44,528		$ 79,202	$ 34,674	$ 1,656,094	1
2	DINING ROOM IMPR-GLASS	1997	973	49	20	49		279	2
3	FOLDING ROOM WALL/DOORS	1998	5,099	255	20	255		1,402	3
4	FLOORING	1998	2,642	264	10	264		1,475	4
5	ALARM INSTALLATION	1998	952	95	10	95		532	5
6	CABINETS	1998	7,745	387	20	387		2,065	6
7	3.5 TON A/C	1998	1,257	126	10	126		639	7
8	NATURE TRAIL LANDSCAPING	1998	18,965	1,897	10	1,897		8,850	8
9	HALLWAY REPAINTING	1998	1,285	129	10	129		600	9
10	DUMPSTER PAD AND FENCING	1998	1,873	375	5	375		1,717	10
11	328 FT POLYVINAL FENCING	1999	2,375	119	20	119		504	11
12	GAZEBO	1999	8,200	410	20	410		1,743	12
13	FLOORING	1999	5,553	555	10	555		2,314	13
14	DINING ROOM REMODEL	1999	6,724	672	10	672		2,802	14
15	ABOVE GROUND TANK	1999	14,566	1,456	10	1,456		6,069	15
16	LANDSCAPING	1999	6,091	870	7	870		3,626	16
17	SECURITY SYSTEM UPGRADE	1999	5,472	782	7	782		3,192	17
18	GAZEBO INSTALLATION	1999	1,998	100	20	100		408	18
19	FRONT LIGHT FIXTURES	1999	4,507	451	10	451		1,578	19
20	STORM WATER PUMP	1999	2,404	343	7	343		1,202	20
21	PARKING LOT	1999	13,819	1,382	10	1,382		4,837	21
22	KITCHEN AND DINING AREA ROOFING	1999	41,800	2,787	15	2,787		9,986	22
23	BREAKROOM FLOORING	2000	1,293	185	7	185		647	23
24	BUG BLOWER	2000	1,264	127	10	127		443	24
25	CARPET IN MULTI-SENSORY ROOM	2000	4,597	919	5	919		2,758	25
26	MULTI-SENSORY ROOM	2000	14,966	379	39.5	379		1,073	26
27	INDEPENDENT WAY GARDEN	2000	34,023	1,701	20	1,701		4,536	27
28	THERAPY ANNEX	2000	1046330	26,488	39.5	26,488		70,638	28
29	NURSE STATION	2001	17,475	448	39	448		896	29
30	DOCTOR OFFICE TILE	2001	822	82	10	82		123	30
31	ENTRYWAYS TILE	2001	1,022	102	10	102		153	31
32	DIETARY ROOM TILE	2001	1,064	106	10	106		160	32
33	ROOM C#1 & C#2 TILE	2001	1,234	123	10	123		185	33
34	TOTAL (lines 1 thru 33)		$ 3,359,745	$ 88,692		$ 123,366	$ 34,674	$ 1,793,526	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forwarc		$ 3,359,745	$ 88,692		$ 123,366	$ 34,674	$ 1,793,526	1
2	SHRUBS AND PLANTS	2002	11,706	585	10	585		585	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,371,451	$ 89,277		$ 123,951	$ 34,674	$ 1,794,111	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numbe WINNING WHEELS # 0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 594,644	$ 71,216	$ 71,216	$	VARIOUS	$ 345,536	71
72	Current Year Purchases	51,723	4,236	4,236		VARIOUS	4,236	72
73	Fully Depreciated Assets	467,541					467,541	73
74	RELATED ORG. ALLOCATION			1,246	1,246			74
75	TOTALS	$ 1,113,908	$ 75,452	$ 76,698	$ 1,246		$ 817,313	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	PATIENT TRANSPORTATI	VARIOUS	VARIOUS	$ 246,223	$ 27,979	$ 27,979	$	VARIOUS	$ 189,428	76
77	SNOW REMOVAL	2000 DODGE PICKUP	2001	28,254	5,651	5,651		5	8,476	77
78	MEDICALLY NECESSARY TRANSPORT					(12,230)	(12,230)			78
79	RELATED ORGANIZATION ALLOCATION					2,929	2,929			79
80	TOTALS			$ 274,477	$ 33,630	$ 24,329	$ (9,301)		$ 197,904	80

E. Summary of Care-Related Asset

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	4,783,336	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	198,359	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	224,978	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	26,619	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	2,809,328	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquirec	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progres

	Description	Cost	
92	Trailer	$ 1,465	92
93			93
94			94
95		$ 1,465	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
   This amount was calculated by dividing the total amount to be amortized _____
   by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
    Beginning _____
    Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facilit

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training wa not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [X]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE 96

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [X]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE 48

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies	80	530	1,250	1,860
3	Classroom Wages (a)	300	20,167		20,467
4	Clinical Wages (b)		10,083		10,083
5	In-House Trainer Wages (c)	757	5,048	11,860	17,665
6	Transportation				
7	Contractual Payments	55	365	860	1,280
8	Nurse Aide Competency Tests		850	1,650	2,500
9	TOTALS	$ 1,192	$ 37,043	$ 15,620	$ 53,855
10	SUM OF line 9, col. 1 and 2 (e)	$ 38,235			

C. CONTRACTUAL INCOME

In the box below record the amount of income you facility received training aides from other facilities

$ 15,796

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	20
2. From other facilities (f)	38
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	9
TOTAL TRAINED	70

(a) Include wages paid during the classroom portion of training. Do not include fringe benefit
(b) Include wages paid during the clinical portion of training. Do not include fringe benefit
(c) For in-house training programs only. Do not include fringe benefit
(d) Allocate based on if the aide is from your facility or is being contracted to be trained i your facility. Drop-out costs can only be for costs incurred by your own aides

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8
(f) Attach a schedule of the facility names and addresse of those facilities for which you trained aides

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		2032 hrs	$ 44,642		$	$	2,032	$ 44,642	1
2	Licensed Speech and Language Development Therapist		1739 hrs	38,322				1,739	38,322	2
3	Licensed Recreational Therapist		1736 hrs	27,080				1,736	27,080	3
4	Licensed Physical Therapist		1916 hrs	47,202				1,916	47,202	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): COGNITIVE THERAPIST		2056	24,779				2,056	24,779	13
14	TOTAL			$ 182,025		$	$	9,479	$ 182,025	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be lis on this schedule.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 479,915	$ 493,555	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	643,196	876,649	3
4	Supply Inventory (priced at COST)	28,197	46,217	4
5	Short-Term Investments	1,103,178	1,996,999	5
6	Prepaid Insurance	10,584	15,774	6
7	Other Prepaid Expenses	10,373	23,415	7
8	Accounts Receivable (owners or related parties)	508,619	1,132,308	8
9	Other(specify): SEE ATTACHED	558,661	566,661	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,342,723	$ 5,151,578	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,416	6,416	12
13	Land	23,500	272,861	13
14	Buildings, at Historical Cost	3,348,604	7,399,370	14
15	Leasehold Improvements, at Historical Cost		151,204	15
16	Equipment, at Historical Cost	1,388,385	1,959,876	16
17	Accumulated Depreciation (book methods)	(2,786,480)	(3,771,519)	17
18	Deferred Charges	2,549	7,411	18
19	Organization & Pre-Operating Costs	22,848	22,848	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(22,848)	(22,848)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTRUCT IN PROGRESS	1,465	2,465	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,984,439	$ 6,028,084	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,327,162	$ 11,179,662	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 79,474	$ 143,305	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	136,094	205,360	29
30	Accrued Salaries Payable	150,342	228,739	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,424	11,581	31
32	Accrued Real Estate Taxes(Sch.IX-B)		1,740	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	REVENUE BONDS		20,000	36
37	Due To/From other Funds	47,487	1,132,308	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 422,821	$ 1,743,033	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	346,835	1,770,266	40
41	Bonds Payable		158,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	PA ADVANCE FOR DT	7,691	49,029	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 354,526	$ 1,977,295	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 777,347	$ 3,720,328	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,549,815	$ 7,459,334	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,327,162	$ 11,179,662	48

***(See instructions.)**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 7,447,570	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 7,447,570	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	70,038	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants	60,204	11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe) AFFILIATES NET INCOME/LOSS	(118,478)	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 11,764	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 7,459,334	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Car	$ 3,833,398	1
2	Discounts and Allowances for all Level	(12,000)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,821,398	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Educatior		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursement	36,816	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,891	14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 38,707	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income**	4,086	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,086	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)	500	27
28	TRANSPORTATION	62,974	28
28a	OTHER REVENUE ATTACHED	2,287	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 65,761	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,929,952	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	854,467	31
32	Health Care	1,858,029	32
33	General Administratior	869,505	33
	B. Capital Expense		
34	Ownership	234,113	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	43,800	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,859,914	40
41	**Income before Income Taxes (line 30 minus line 40)****	70,038	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 70,038	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,805	2,180	$ 46,687	$ 21.42	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,375	6,869	126,829	18.46	3
4	Licensed Practical Nurses	14,310	15,271	250,444	16.40	4
5	Nurse Aides & Orderlies	65,436	68,756	677,819	9.86	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	5,687	6,016	130,166	21.64	7
8	Rehab/Therapy Aides	5,556	6,237	71,181	11.41	8
9	Activity Director	1,736	2,000	27,080	13.54	9
10	Activity Assistants	1,952	2,080	26,213	12.60	10
11	Social Service Worker	5,850	6,090	82,696	13.58	11
12	Dietician	1,859	1,891	31,545	16.68	12
13	Food Service Supervisor					13
14	Head Cook	7,513	8,057	65,053	8.07	14
15	Cook Helpers/Assistants	14,592	15,518	112,397	7.24	15
16	Dishwashers					16
17	Maintenance Worker	7,701	8,493	80,539	9.48	17
18	Housekeepers	10,246	10,995	86,513	7.87	18
19	Laundry	7,359	7,957	60,361	7.59	19
20	Administrator					20
21	Assistant Administrator	1,896	2,080	43,895	21.10	21
22	Other Administrative					22
23	Office Manager	1,882	2,110	21,133	10.02	23
24	Clerical	3,623	4,053	31,546	7.78	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,952	2,112	25,057	11.86	31
32	Other Health Care(specify)	6,134	6,406	97,959	15.29	32
33	Other(specify) TRANSPORTATI	3,130	3,330	26,494	7.96	33
34	TOTAL (lines 1 - 33)	176,594	188,501	$ 2,121,607 *	$ 11.26	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	3	$ 165	1,3	35
36	Medical Director	30	3,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	2,400	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultan				41
42	Respiratory Therapy Consultan				42
43	Speech Therapy Consultant	10	645	10a,3	43
44	Activity Consultant	24	960	11,3	44
45	Social Service Consultant				45
46	Other(specify) EQUESTIAN THER	185	4,584	11,3	46
47	PHYSIATRIST CONSULTS	172	21,500	9,3	47
48	PSYCHIATRIC EVALS	11	1,075	10a,3	48
49	TOTAL (lines 35 - 48)	483	$ 34,329		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	236	4,118	10,3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	236	$ 4,118		53

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ELIZABETH GOODMAN	ADMINISTRATOR	NONE	$
(SALARY INCLUDED IN MANAGEMENT FEES- LINE 17 COL 3)			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.			$

B. Administrative - Other

Description	Amount
AMERICAN HEALTH ENTERPRISES	$ 196,600
TOTAL (agree to Schedule V, line 17, col. 3)	$ 196,600
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
POLARIS	MEDICARE CONSULT	$ 8,448
LINDGREN, CALLIHAN, VAN	AUDIT FEES	9,100
BKD, LLP	MEDICARE COST REPORT	4,245
JOHN PYSE	COMPUTER CONSULTANT	19,862
ACHIEVE	SOFTWARE MAINT. FEES	3,027
MAS 90	SOFTWARE MAINT FEES	1,445
CREATIVE SOLUTIONS	MEDICAL RECORDS SOFT.	3,978
CDW	COMPUTER/SOFTWARE UPI	5,382
INTERNET SERVICES	INTERNET FEES	958
JCM	EMPLOYEE PREFORM SOFT	870
UNISOFT	MENU SOFTWARE SUPPORT	972
MISC SOFTWARE VENDORS	COMPUTER/INTERNET	1,696
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 59,983

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 80,596
Unemployment Compensation Insurance	3,820
FICA Taxes	159,902
Employee Health Insurance	59,669
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE,DENTAL,DISABILITY INSURANCE	34,135
RETIREMENT	9,572
PHYSICALS	497
CHILD CARE	16,401
MISC BENEFITS	14,943
RELATED PARTY LPC	12,947
RELATED PARTY AHE, INC.	17,615
TOTAL (agree to Schedule V, line 22, col.8)	$ 410,097

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,797
Health Care Worker Background Check	
(Indicate # of checks performed 103)	724
CARF FEES	1,280
DUES, FEES, SUBSCRIPTIONS	7,851
OTHER MISC FEES/PROMOTIONS	10,373
RELATED PARTY ALLOCATION	513
Less: Public Relations Expense	(2,439)
Non-allowable advertising	(2,919)
Yellow page advertising	(90)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,090

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ (4,139)
AND SEMINAR COST	
In-State Travel	
TOTAL TRAVEL AND	
Seminar Expense	18,050
RELATED PARTY ALLOCATION	255
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,166

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING	07/2001	$ 6,373	5 YRS	$	$ 1,275	$ 1,275	$ 1,275	$ 1,275	$ 1,273	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 6,373		$	$ 1,275	$ 1,275	$ 1,275	$ 1,275	$ 1,273	$	$	$

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/02 Ending: 06/30/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union **NO**

(2) Are there any dues to nursing home associations included on the cost repor **YES**
If YES, give association name and amount **ILLINOIS HEALTH CARE ASSOC. $4104**

(3) Did the nursing home make political contributions or payments to a politic
action organization? **NO** If YES, have these cost
been properly adjusted out of the cost report

(4) Does the bed capacity of the building differ from the number of beds licensed at t
end of the fiscal year **NO** If YES, what is the capacity

(5) Have you properly capitalized all major repairs and equipment purchases **YES**
What was the average life used for new equipment added during this perio **7 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expen
and the location of this expense on Sch. V. **19,117** Line **10**

(7) Have all costs reported on this form been determined using accounting procedur
consistent with prior reports **YES** If NO, attach a complete explanation

(8) Are you presently operating under a sale and leaseback arrangement **NO**
If YES, give effective date of leas

(9) Are you presently operating under a sublease agreement YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions f
Schedule VII)? YES NO **X** If YES, please indicate name of the facility
IDPH license number of this related party and the date the present owners took ov

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departme
of Public Aid during this cost report period. **43,800**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule
for an individual employee **NO** If YES, attach an explanation of the allocation

(13) Have costs for all supplies and services which are of the type that can be billed
the Department of Public Aid, in addition to the daily rate, been properly classifi
in the Ancillary Section of Schedule V **YES**

(14) Is a portion of the building used for any function other than long term care services f
the patient census listed on page 2, Section B **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attac
a schedule which explains how all related costs were allocated to these functior

(15) Indicate the cost of employee meals that has been reclassified to employee benef
on Schedule V. $ **NONE** Has any meal income been offset agains
related costs? **YES** Indicate the amount $ **1,891**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel **NO**
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation f
residents? **YES** If YES, please indicate the amount of income earned from such
program during this reporting period. $ **55,964**
c. What percent of all travel expense relates to transportation of nurses and patient **100%**
d. Have vehicle usage logs been maintained **YES**
e. Are all vehicles stored at the nursing home during the night and all oth
times when not in use **YES**
f. Has the cost for commuting or other personal use of autos been adjust
out of the cost report **N/A**
g. Does the facility transport residents to and from day training YES
Indicate the amount of income earned from providing suc
transportation during this reporting period $ NONE

(17) Has an audit been performed by an independent certified public accounting firm **YES**
Firm Name: **LINDGREN, CALLIHAN, VANOSDOL, CPA'S** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this co
been attached? **YES** If no, please explain

(18) Have all costs which do not relate to the provision of long term care been adjusted o
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of servic
performed been attached to this cost report **NO**
Attach invoices and a summary of services for all architect and appraisal fee